



**Texas Department of Insurance, Division of Workers' Compensation**  
Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor's Name and Address:  CASA VIEW CHIROPRACTIC CLINIC 10622 SHILOH RD DALLAS, TX 75228	MFDR Tracking #:	M4-10-1692-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #:  HARTFORD UNDERWRITERS INSURANC REP. BOX # 47	Date of Injury:	
	Employer Name:	
	Insurance Carrier #:	

### PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as stated on Table of Disputed Service: "LACK OF RESPONSE"

Principle Documentation:

1. DWC 60 package
2. CMS-1500
3. EOB(s)
4. Total Amount Sought - \$450.00

### PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "PPO Discount taken Rule 134.1(e)."

### PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service(s)	Amount in Dispute	Amount Due
06/12/2008	45	99456-WP	\$450.00	\$0.00
Total Due:				\$0.00

### PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. Medical Fee Dispute Resolution (MFDR) received the DWC-60 on 11/12/2009. The date of service in dispute is 06/12/2008.
2. 28 TAC Section 133.307 (c) (1) (A) states in part, "A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.
3. This dispute was not submitted timely.

The Division concludes that this dispute was not filed in the form and manner prescribed under Rule 133.307 Section (c) (1) (A). As a result, the amount ordered is \$0.00.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311  
28 TAC Sec. § 133.307 (c) (1) (A)

**PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to \$0.00 reimbursement.

12/29/2009

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Auditor

\_\_\_\_\_  
Date

**PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**